



UNGASS COUNTRY PROGRESS REPORT

SEYCHELLES

Reporting for the Period: January 2008 – December 2009

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INTRODUCTION

In Seychelles, the HIV and AIDS epidemic is concentrated, yet it poses a big challenge and threatens to reverse the gains the country has made in its socio-economic development and stability since its independence. When estimating HIV incidence for countries one is often met with technical and operational difficulties. HIV prevalence among the age group 15 to 19 is commonly taken as a proxy of incidence, given that it is considered as recent infections. In Seychelles, among first time ANC attendees aged 15 to 19 for the year 2009, HIV prevalence stood at 2.5%. This statistics may be indicative of not only the future HIV trend in Seychelles but also an indication of the socio-economic challenge the pandemic may produce.

However, given the potential challenges posed by the epidemic, the country has not developed capacity to estimate the prevalence.

The UNGASS Declaration of Commitment on HIV/AIDS 2010 report was compiled by the Department of Health. The process was conducted by a work team coordinated by HIV AIDS CONTROL Unit. The team comprised members from CDCU, Health Statistics Unit and the National Statistical Bureau and benefited from the technical assistance by the UNAIDS. The team coordinated the assembling of data and report writing.

This report has been compiled with participation and involvement of the Public Sector (various Government Ministries and Departments), Civil Society, Private Sector and UN team. In producing the report, we also relied mainly on existing data from the Department of Health. These included data sourced from the Health Statistics Unit, CDCU, and Health Statistics Reports.

Key informants, including Government institutions, Civil Society, Un agencies and Private Sector, completed the National Composite Policy Index Questionnaire. Officials of the Ministries of Employment, Education and Health provided data as well as additional documentation on HIV/AIDS workplace policies and practices. The Ministry of Education conducted a rapid desk survey on life skills education in schools.

In the data compiling process and report writing, it became evident that existing data on certain indicators are not easily obtainable or available in the format recommended by UNGASS Guidelines on the Construction of Indicators. During the course of the exercise, the urgent need for a monitoring and evaluation framework became evidently clear. Had an efficient and effective monitoring and evaluation framework been in place, it would have rendered the exercise easier.

It also became clear during the process of data assembling and report writing that the existing information systems is not geared to the collection of all data required in the format recommended by UNGASS Guidelines on the Construction of Indicators. Nevertheless, this process can serve to sensitise us to data requirements and the need to construct information systems to address this specific data requirement.

There is a need to continuously engage various partners to include Commitment of Declaration Indicators into existing periodic surveys and routine data collection. Indicators and data elements recommended for

both the public and the private sector should take into account data requirements of the UNGASS Guideline for the Construction of Indicators. Similarly, routine data collection of the Education Department should take into account data requirements on HIV/AIDS life skills education.

It was evident in the various consultation forums, including the validation meetings, that there is a zeal within the various services to contain the epidemic before the situation escalates. In this light a monitoring and evaluation framework is an urgent necessity. The process of compiling this report was instrumental in renewing this engagement. During the process it was also noted that though the country compiled and prepared the three previous UNGASS reports, 2003 , 2005 and 2007, these reports were not included in the aggregated UNGASS report.

I. TABLE OF CONTENTS

1.	Introduction	i
2.	Status at a glance	iv
3.	Overview of the AIDS epidemic	2
4.	National response to the AIDS epidemic	7
5.	National commitment and action	12
6.	National programmes	17
7.	Best Practices	28
8.	Major challenges and Remedial actions	30
9.	Support required from country's development partners	32
10.	Monitoring and evaluation environment	36
ANNEXES		
ANNEX 1:	Consultation/preparation process for the country report on monitoring the progress towards the implementation of the Declaration of Commitment on HIV/AIDS	38
ANNEX 2	Data Sources and references	39

II. STATUS AT A GLANCE

<p>NATIONAL COMMITMENT AND ACTION</p> <ol style="list-style-type: none"> 1. Domestic and international AIDS spending by categories and financing sources: Funding matrix uploaded 2. National Composite Policy Index: Separate document uploaded
<p>NATIONAL PROGRAMME AND BEHAVIOUR</p> <p>Prevention</p> <ol style="list-style-type: none"> 3. Percentage of donated blood units screened for HIV in a quality assured manner: 100% 4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy: 95.21% 5. Percentage of HIV-positive pregnant women who received antiretroviral to reduce the risk of mother-to-child transmission: 100% 6. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV: 100% 7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results: Data available but not disaggregated 8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know their results: Not Available 9. Percentage of most-at-risk populations reached with HIV prevention programmes: Not Available 10. Percentage of orphaned and vulnerable children aged 0–17 whose households received free basic external support in caring for the child: Not Available 11. Percentage of schools that provided life skills-based HIV education in the last academic year: 100%
<p>KNOWLEDGE AND BEHAVIOUR</p> <ol style="list-style-type: none"> 12. Current school attendance among orphans and among non-orphans aged 10–14: Not Available 13. Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission: Not Available 14. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission: Not Available 15. Percentage of young women and men aged 15–24 who have had sexual intercourse before the age of 15: Not Available 16. Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months: 16.6 17. Percentage of women and men aged 15–49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse: 68% 18. Percentage of female and male sex workers reporting the use of a condom with their most recent client: Not Available 19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner: Not Available 20. Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse: Not Available 21. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected: Not Available
<p>IMPACT</p> <ol style="list-style-type: none"> 22. Percentage of young women and men aged 15–24 who are HIV infected: Not available 23. Percentage of most-at-risk populations who are HIV infected: Not Available 24. Percentage of adults and children with HIV known status to be on treatment 12 months after initiation of antiretroviral therapy: 93.62%
<p>UA Health Sector Indicators : Separate document uploaded</p>

III OVERVIEW OF THE HIV AND AIDS EPIDEMIC IN SEYCHELLES

HIV and AIDS in Seychelles represent a concentrated epidemic. The burden of disease related to AIDS was relatively low at the end of 2009, but the increasing number of new cases (52 for the only year of 2009) announces a heavier burden for the country. Prevention, treatment, care and support programmes are national concerns. The National Policy on HIV and AIDS as well as the National Strategy call for coordinated action on the part of government, non-governmental organisations, the private sector, community groups and the general population. In this regard, the implementation of the National Strategic Plan for 2005 to 2009 is progressing forward steadily, and the country is currently in the process of reviewing this strategic plan and drafting a new one for the period 2010-2014. Inevitably, there are a number of challenges including the implementation of the “Three Ones”.

To provide common policies, directions and a road map, a country is required to have a National HIV and AIDS Strategic Plan, which mirrors the aspirations and contributions of all sectors of the society. A complete Strategic Plan with quantitative and qualitative aspects will be particularly helpful in pooling resources for sustained, coordinated action. This facilitates effective means of intervention, hence meeting the needs of the country in the field of HIV and AIDS.

The Ministry of Health and Social Development and Social Development leads the HIV/AIDS fight since the detection of the first case of HIV infection in 1987. Government commitment has been expressed through the creation of the national AIDS programme, adoption of a National Policy endorsed by the President, creation of the National AIDS Council and National AIDS Trust Fund, funding of activities by government and external resources, and adherence to international conventions and principles including the UNGASS declaration. Though HIV and AIDS pandemic is not yet a problem on the scale of some other countries within the sub-saharan region, Seychelles has made significant strides in developing and implementing appropriate policies to respond to the potential challenge of HIV and AIDS. However, currently the fight is still mainly perceived as a health issue and the need for a significant move to a multi-sectoral approach cannot be overemphasized (National AIDS Council, 2005)

HIV/AIDS presents a real and surmountable challenge for Seychelles. Despite the country's status as middle-income country, and small island state, the HIV/AIDS situation in Seychelles requires continued attention from its Government, the Civil Society, The Private Sector, the general public and the international community. Being a small island state presents Seychelles with a particular problem. Given the small population and inadequate human capital and the tight sexual network, Seychelles becomes more vulnerable to the effects of the pandemic“*The pandemic will not only have a social impact but also an economic impact at the individual and national levels as the country will most feel the brunt of providing medical care for those infected, and losing human resources, especially those who are economically active*” (National AIDS Council, 2005)

The National Strategic Plan 2005 to 2009 was drafted by the Ministry of Health and Social Development and major local partners, in collaboration with UNDP, UNAIDS and WHO. The national strategic plan is intended to guide the country's response to the epidemic. It is not a plan for the health sector specifically as no single sector, will by itself overcome the HIV/AIDS epidemic. It was the product of a workshop with the aim of achieving consensus on the HIV and AIDS national Strategies and involved over hundred participants who consequently reviewed the draft plan and made recommendations. The evaluation of this strategic plan, planned in 2010, will inform us on how Government departments, organisations and stakeholders used this framework as a basis to develop their own plans thus ensuring a well coordinated effective and efficient response.

In countries that have had significant successes in slowing down or reversing the trends in HIV infection, the key elements contributing to the successes have been consistent interest and commitment at the highest levels of leadership and persistent action by all groups in society, including people living with HIV and AIDS. These imply massive mobilisation of resources dedicated to prevention through education, information and communication, control through well established public health measures, caring through clinical services and support for those infected and affected.

There is strong political will and commitment over the years with regards to HIV and AIDS. In Seychelles, we will recall the various interventions made by the President of the Republic and the Minister of Health and Social Development. Below are few pertinent statements made by the above mentioned political personalities on HIV and AIDS related issues:

The National AIDS Council (NAC) is a multi-sectoral and multidisciplinary committee in conformity with the National Policy on the Prevention and Control of HIV/AIDS in Seychelles. The National AIDS Committee was established in recognition of the need for participation of all other sectors of society in the co-ordination and monitoring of the response. Members of the NAC are experts in their field and their participation is a tremendous contribution in addressing the HIV and AIDS issues in Seychelles. The terms of reference of the Council are:

- Creating and strengthening partnerships for an expanded national response to the AIDS epidemic among all sectors;
- Advising on the National Strategic Plan on HIV/AIDS in Seychelles;
- Determining activities for the Strategic Plan;
- Advising the Cabinet on issues pertaining to HIV/AIDS policy;
- Planning, co-ordination, monitoring and evaluation of the national response to HIV/AIDS/STIs;
- Recommending appropriate research;
- Advocating for the effective involvement of sectors and organisations in implementing programmes and strategies;
- Mobilising resources for programme implementation;
- Initiating and/or undertaking policy formulation and review;
- Encouraging greater involvement of persons living with HIV or AIDS;

The membership of the NAC is as follows:

- Ministers;
- Principal Secretaries;
- Representatives of selected national organisations and associations. These include Private Sector; People living with HIV/AIDS; Non-government organisations; Faith-based organisations; Trade Union; Women; Children; Youth; District administrators; Legal and Human Rights; Sport; Media; and Men's Association;
- Individuals selected in their own private capacity; and the
- AIDS prevention and control programme Unit

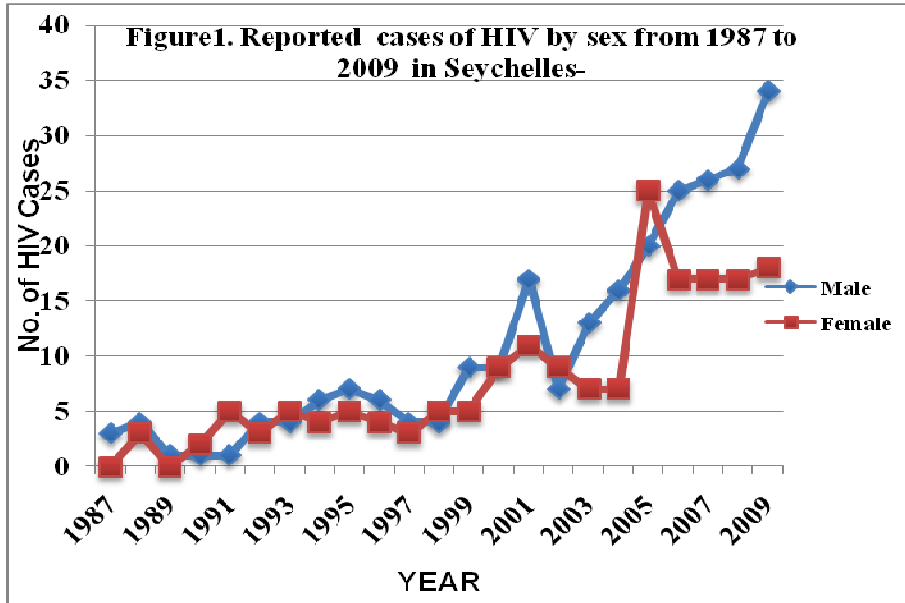
Over the last few years we have seen a growth of the partnership and mobilisation of various sectors across the country. Funds for HIV and AIDS programmes can be mobilised from many sources, both national and international. To reflect the national character of the epidemic and action against HIV and AIDS, a National AIDS Trust Fund has been established in 2002 and revived in 2008.

Government's commitment to address HIV and AIDS in Seychelles has been demonstrated by consistent increases in the allocation towards HIV and AIDS over the last few years. This is illustrated by budgetary trends of the health budget as well as by the specific HIV and AIDS spending.

For the period of 2008-2009, there were no methods used in Seychelles to estimate the prevalence and incidence of HIV and AIDS. Statistics on the epidemic is obtained from patient records from the sentinel sites.

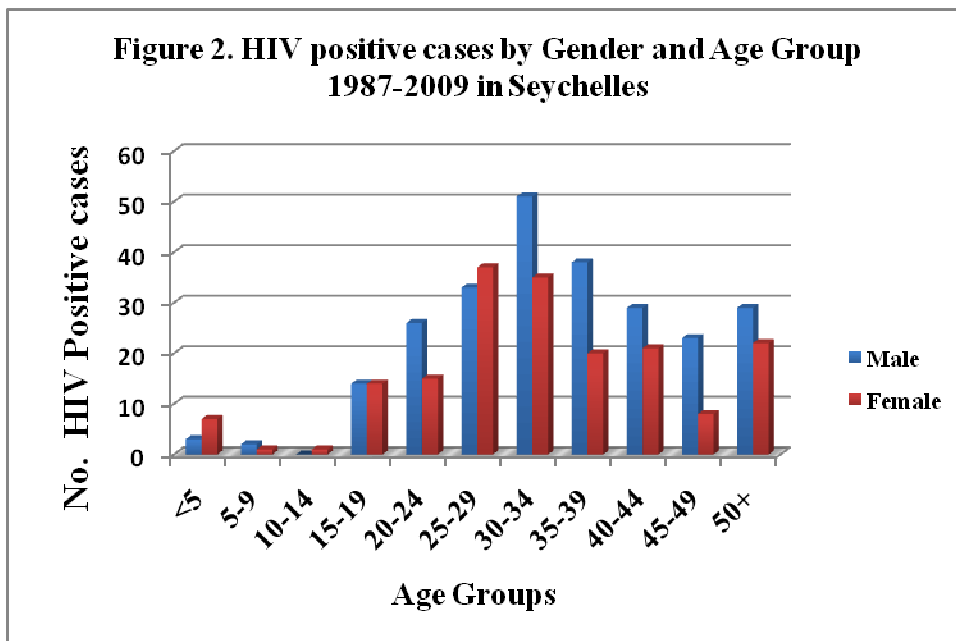
The first recorded HIV infected person in Seychelles was diagnosed in 1987 and the first recognized full-blown AIDS case was reported in 1992⁽¹⁾. Figure 1 shows the cumulative number of HIV infections, AIDS cases and related deaths since the beginning of the epidemic in Seychelles. As at December 2009, 194 persons had been diagnosed with AIDS, while 429 persons were recorded as having been tested positive for HIV infection. Antiretroviral therapy has been made available free of charge to all patients in need since August 2002.

Figure 1 shows the number of HIV reported cases by age and sex from 1987 to 2009. From the statistics, in 2009, there were a cumulative number of 248 males and 181 females diagnosed with HIV infection or a ration of 1.37 males to 1 female.



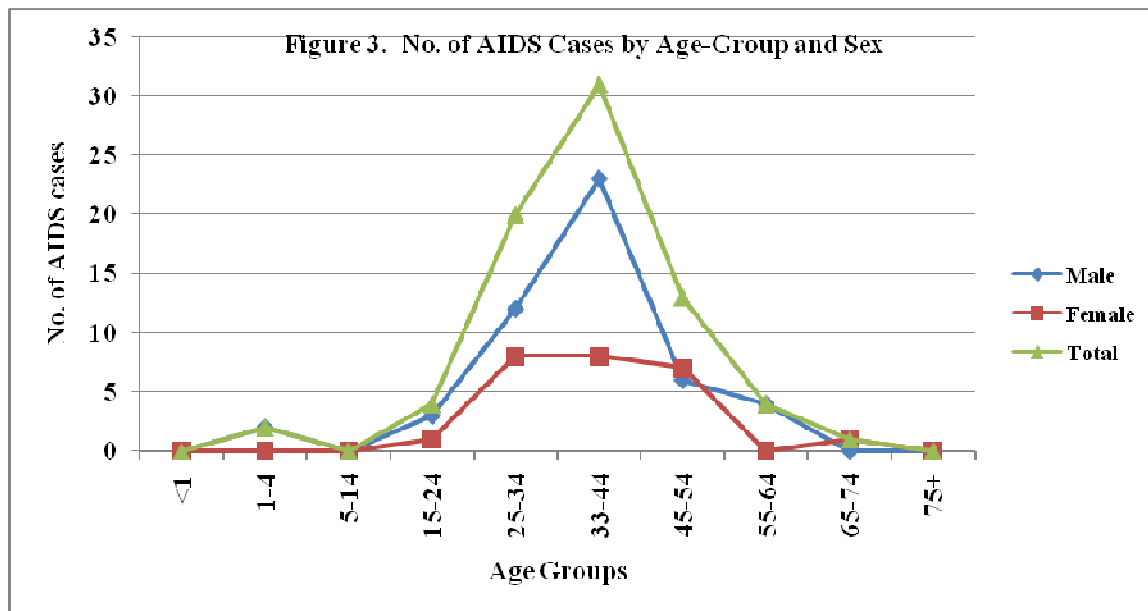
Source: Communicable Disease Control Unit, Department of Health

Figure 2 shows the reported HIV positive cases by gender and age group for the years 1987 to 2009. Most of the reported HIV positive cases were in the 25 to 39 age group. Except for the age group 25 to 29, males were the most infected in all age categories.



Source: Communicable Disease Control Unit, Department of Health

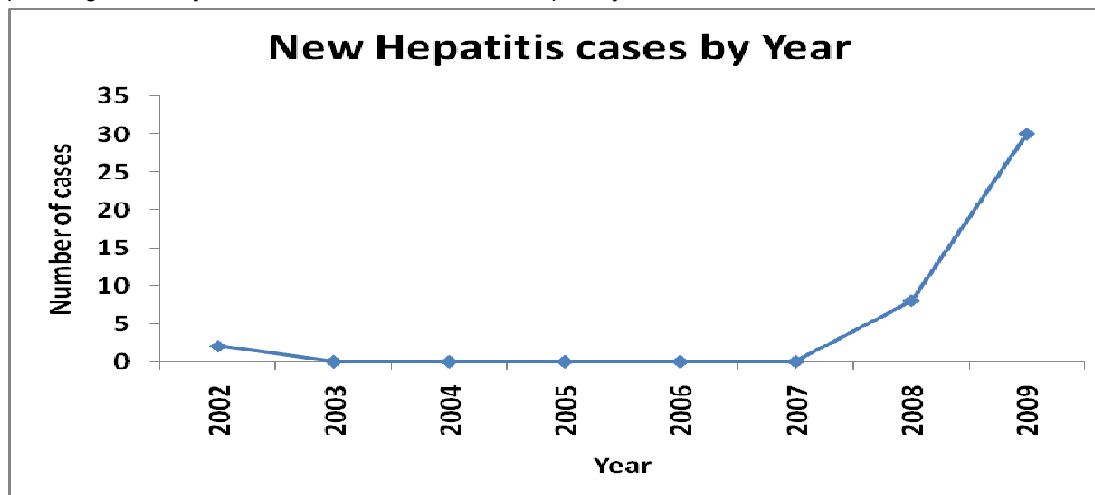
Figure 3 shows the number of reported AIDS cases by gender and age group for the years 1987 to 2009. Most of the reported HIV positive cases were in the 25 to 54 age group (85.3%). Males were the most infected in general (66.7%).



Source: Communicable Disease Control Unit, Department of Health

HIV&AIDS and Hepatitis C

In the area of the fight against HIV and AIDS, Hepatitis C is currently a newly emerging Public Health issue in Seychelles. In 2002, there were 2 Hep C cases. No new cases were detected between 2003 and 2007. In 2008, there were 8 new Hep C cases. In 2009, there were 32 new Hep C cases. All the new cases are located among the Intravenous Drug Users. This poses a serious concern for HIV efforts, and shows the pressing necessity to better address the IDUs as a priority.



Source: Communicable Disease Control Unit, Department of Health

IV. NATIONAL RESPONSE TO AIDS EPIDEMIC

Seychelles is a multi-ethnic society, which has its origin on the three continents: Africa, Asia and Europe. The main religion is Christianity and other major religions are represented. Religious belief is respected and seems to have strong influence to the people's values and daily practices.

The estimated population for Seychelles in 2009 was 87298. The Total Fertility Rate in 2009 was 2.38. Life expectancy at birth was 72.89 years (68.44 for males and 77.99 years for females) and infant mortality rate was 10.76 per 1,000 births in 2009. In 2009, the 15 to 49 adult population was estimated at 50004. There were 43,160 males and 41,872 females or an approximate sex ratio of 1031 men for every 1000 women. The Total Fertility Rate in 2007 was 2.2. The mean age of childbearing was 26.5 years and the mean age at first marriage was 32 years for male and 30 years for female.

Seychelles' economic and social progress since independence has been very remarkable. According to the Human Development Report (2009), Seychelles is currently ranked 57th in the world (Human Development Index). However, the economy is very vulnerable due to its dependence on two main sectors, tourism (directly contributes 10% to 15% of GDP and two-thirds of foreign exchange receipts) and fisheries, which provide the bulk of national income as well as foreign exchange. Tourism especially is very sensitive to changes in the international economic and political environment. Furthermore, the economy of Seychelles is, to a very large extent, dependent on imports. With the international financial crisis in 2008-2009, the economy of Seychelles could not achieve the predictions even though the damages have been mitigated by a resisting tourism sector. Another difficulty came to complicate the situation in regards to fisheries: pirates who are a real threat as so far they invade Seychelles waters and make the fisheries sector more and more vulnerable.

Seychelles is a multiparty democracy politically divided into 25 districts, with central government led by a President. Elected Members of the National Assembly bring forward debates for policy discussion and decision-making by the National Assembly. The Government allocates funds across ministries and sectors according to priority needs.

Seychelles has a comprehensive health structure, which comprises of 1 central referral hospital, 3 cottage hospitals, 1 rehabilitative hospital, 1 mental hospital, 1 youth health centre and 16 district health centres located throughout the country with a decentralised system of providing basic health services in the community. Equity is a fundamental principle behind the financing and organization of health care system in Seychelles. Government-funded services are free of charge to every citizen and are complemented by a private service system, based on articles 29 and 31 of the Country's Constitution .:

29 "The state recognises the right of every citizen to protection of health and to the enjoyment of the highest attainable standard of physical and mental health and with a view to ensuring the effective exercise of this right the State undertakes -

(a) to take steps to provide for free primary health care in State institutions for all its citizens;
(b) to take appropriate measures to prevent, treat and control epidemic, endemic and other diseases;

(c) to take steps to reduce infant mortality and promote the healthy development of the child;
(d) to promote individual responsibility in health matters;

(e) to allow, subject to such supervision and conditions as are necessary in a democratic society, for the establishment of private medical services.

31. The State recognises the right of children and young persons to special protection in view of their immaturity and vulnerability and to ensure effective exercise of this right the State undertakes –

The link between HIV and prostitution and substance and alcohol abuse was recognized by the President when in 2008, he asked the Ministry of Health and Social Development to “*remain at the forefront of the fight against social ills affecting our societies such as HIV/AIDS, prostitution and substance and alcohol abuse.*” (State of the Nation speech, 2008)

The Seychelles' response to the pandemic dates back to 1987 when the first HIV infection was detected. This includes a short term plan of 1987 to 1988, a medium term plan of 1989 to 1993, thereafter ongoing annual plans, and a strategic plan for HIV/AIDS/STIs in 2001. The surveillance of the epidemic is conducted at sentinel points of Communicable Disease Control Unit, District Health Centres, private health centres, antenatal clinics, Occupational Health Unit and the blood bank in the Ministry of Health and Social Development and reveals that there is an increasing trend in HIV infections. As at December 2009, **428** persons (249 males, 179 females) have been tested positive for HIV infections. Several risk factors have been associated with increased risk of HIV infection, such as injecting drug use, increasing practice of commercial sex and increase in number of men who have sex with men.

An AIDS-IEC Committee was formed in 1988 within the Ministry of Health and Social Development and supported by the Technical Advisory Committee for HIV/AIDS/STIs a year later. Following a workshop on AIDS counselling in 1991, the first non-governmental organization to deal with HIV/AIDS, the HIV/AIDS Support Organisation (HASO) was born and later registered in 1995. An expanded UN Theme Group for HIV/AIDS was created in 1996 by the resident WHO Liaison Officer.

All previous HIV/AIDS plans were driven solely by the health sector. As it became clear worldwide that HIV/AIDS is not only a health problem but also a development crisis, the need for a multi-sectoral approach became more evident.

The development of the National Policy for the Prevention and Control of HIV/AIDS and STIs was initiated by the Government of Seychelles in early 2001 with a view to involve all sectors of society in the fight against HIV/AIDS. However, it was mostly health-driven. With the formation of the NAC in May 2002, the strategic process was facilitated and the draft has been reviewed and amended by a multi-sectoral team. The process was designed in respect to the UNAIDS guidelines on strategic planning and lessons learned. The process benefited from appropriate technical and financial support from UNAIDS, WHO, UNDP, Government of Mauritius and the Indian Ocean Initiative against HIV/AIDS.

Guidance was obtained through a steering committee comprising of representatives of different ministries and organisations. The situation and response analyses were further facilitated by information based on interviews of relevant stakeholders and review of existing documents. These analyses enabled to identify vulnerability and risk factors, and priority areas for interventions.

The formulation process started during a multi-sectoral workshop from 12th –15th August 2003. For each priority area, strategic objectives, with target activities, opportunities for implementation and key implementing bodies were identified. Strategies were prioritized in relation to acceptability, feasibility, technical soundness and impact. It was also stressed on the importance of the flexibility of the plan. The workshop was facilitated by the UNAIDS Regional Programme Adviser, WHO Liaison Officer, UNDP/UNAIDS Programme Manager and the National HIV/AIDS Coordinator in Mauritius, who also guided the team to draft the document.

The National Strategic Plan was validated by all stakeholders during a workshop.

Due attention was paid to the following key principles of strategic planning:

- Participatory approach which ensures full involvement and ownership by all relevant stakeholders;
- Determinants-driven planning;
- Prioritisation of problems and strategies based on analysis of trends and current status of the epidemic and the response;
- Relevance to the Millennium Declaration Goals and particularly to the UNGASS Declaration.

The process can be summarised in the following major steps:

- Formulation and implementation of the National Policy framework which triggers multi-sectoral mobilisation;
- Resource mobilisation including technical resources;
- Information gathering including sectoral reviews and surveys;
- Preliminary draft of the national strategic plan by the MOH;
- Prioritisation and planning workshops at national, sectoral and community levels;
- Costing and Budgeting;
- Consultation at political and national levels;
- Approval by the cabinet;
- Dissemination to all stakeholders.

The National Strategic Plan 2005 to 2009 calls for the following structures for its implementation (National AIDS Council, 2005):

The National AIDS Council (NAC) was launched on 24th May 2002 and has met on several occasions since. It has been appointed the Country Coordinating Mechanism (CCM) for the Global Fund Proposal. Other important items on the agenda have been: Legislation and regulations; Working Groups by the different sectors; Counselling needs; National AIDS Trust Fund; Antiretroviral therapy; Specific individual needs of PLWHAs; Stigma and Discrimination. The NAC reports to the Cabinet through the Minister for Health.

The National AIDS Trust Fund was created for massive mobilisation of resources for prevention through education, information and communication, control through well established public health measures and caring through clinical services and support for those infected and affected. Its terms of reference are:

- To create national interest and commitment for the prevention and control of HIV and AIDS and the care of those infected and affected;
- To mobilise resources for HIV/AIDS programmes;
- To promote and support national programmes on HIV/AIDS

Currently, the Government of Seychelles committed itself to provide amount of 100,000 \$ annually.

The Technical Advisory Committee for HIV/AIDS in the Ministry of Health and Social Development meets fortnightly to discuss issues pertaining to care and support, testing, treatment, surveillance and other guidelines. Main issues are research and surveillance; care and counselling; Blood Safety; Provision and Difficulties with antiretroviral therapy; Resource mobilisation; STI management; community activities; IEC; laboratory; and others e.g Contact Tracing; Confidentiality.

The AIDS Prevention and Control Programme (also referred to as AIDS Programme) is a unit with full-time AIDS Programme Manager, a Health Promotion Officer and a secretary under the Public Health Division in the Ministry of Health and Social Development. It is responsible for advocacy and prevention aspects of HIV/AIDS, reaching a wider community. However, it is much involved in planning, facilitation, coordination, implementation, monitoring and evaluation of activities. The section has received assistance from WHO, UNAIDS and UNDP officials. The AIDS Programme also holds the NAC Secretariat, though not operating to the maximum.

The Civil Society (including NGOs, Faith-Based Organisations) and the Private Sector are involved in the national response, represented in various structures and are consulted before any interventions.

The Social Services Committee comprises of representatives from Ministry of Social Affairs and Employment, Social Security Scheme, CDCU, AIDS Programme, Medical Social Worker, Representatives of Medical Ward and North East Point Hospital, HASO and FAHA. It discusses and sorts out problems related to social services, for example, financial benefits, home care and employment issues.

Focal persons are in contact for dialogue between organizations and the AIDS Programme and can be co-opted on any committee as necessary.

Though a strategic plan was in place during the reported period (2008-2009), sectoral operational plans were not developed. This should be considered for the next NSP. The development of the operational plan will be a chance to incorporate and develop some important features of the national health system and should be guided by a number of important principles. These could include, amongst others;

- Developing a sustainable health programme and strengthening the National Health System and;
- Reinforcing the key Government strategy of prevention and reinforce the multisectoral dimension of the fight against HIV and AIDS ;

- Providing a comprehensive continuum of care and treatment and by so doing, maintain the Universal Access;

The Constitution makes provision for any law, programme or activity, which has as its object the amelioration of the conditions of all persons, including disadvantaged persons or groups.

Policies on HIV - Workplace HIV and AIDS policies, programmes and practices in Seychelles are formulated and implemented within the legislative and policy framework. Existing laws and policies ensure that those infected with HIV or those living with HIV are not subjected to discrimination, they receive necessary support and care, and that risk to HIV infection is reduced in the workplace. Monitoring and evaluation systems of workplace HIV and AIDS policies and programmes are being further developed.

Seychelles has created a legislative and policy framework for protection of employees infected with HIV against discriminatory and unfair labour practices in the workplace. The laws and policies are applicable in both private and public sector. Specific public service regulations prescribing minimum standard for HIV and AIDS workplace programmes are also available.

A NATIONAL COMMITMENT AND ACTION INDICATORS

Domestic and international AIDS spending by categories and financing sources

National funds spent by governments on HIV/AIDS are a measure of national government commitment to fight HIV/AIDS. UNGASS indicator guidelines require information on national funds to comprise expenditure on the following four categories of programmes and totals for each to be specified separately.

- STI control activities
- HIV prevention
- HIV/AIDS clinical care and treatment
- HIV/AIDS impact mitigation

The guidelines further require that costs of any multilateral or bilateral international donor-funded government programmes to be included. All local NGO programmes should be excluded, except programmes that are funded by national government.

The following is the spending snapshot for both 2008 and 2009. It is to be noted that due to insufficient time for gathering this kind of information, it is believed that some categories of spending are underestimated.

Table 1. HIV&AIDS related spending in 2008

2008 AIDS Spending Categories	TOTAL US Dollars	Central / National	Social Secur ity	UN Agencie s	All Other Multilat eral	All Other Internat ional	For- profit instit ution s	House old funds
TOTAL	575,899	479,902	1,060	69,606	11,557	10,954	353	2,467
1. Prevention (sub-total)	100,842	24,451	1,060	50,000	11,557	10,954	353	2,467
2. Care and Treatment (sub-total)	270,677	270,677	0	0	0	0	0	0
3. Orphans and Vulnerable Children (sub-total)	123,189	123,189	0	0	0	0	0	0
4. Program Management and Administration Strengthening (sub-total)	19,606	0	0	19,606	0	0	0	0
5. Human resources (sub-total)	61,585	61,585	0	0	0	0	0	0
6. Social Protection and Social Services excluding Orphans and Vulnerable Children (sub-total)	0	0	0	0	0	0	0	0
7. Enabling Environment (sub-total)	0	0	0	0	0	0	0	0
8. Research (sub-total)	0	0	0	0	0	0	0	0

Table 2. HIV&AIDS related spending in 2009

2009	TOTAL					
AIDS Spending Categories	US Dollars	Central / National	Bilaterals	UN Agencies	For-profit institutions / Corporations	House hold funds
TOTAL	581,459	462,278	24,800	87,780	2,466	4,135
1. Prevention (sub-total)	139,670	52,412	24,800	55,858	2,466	4,135
2. Care and Treatment (sub-total)	212,410	212,410	0	0	0	0
3. Orphans and Vulnerable Children (sub-total)	90,547	90,547	0	0	0	0
4. Program Management and Administration Strengthening (sub-total)	72,646	51,774	0	20,873	0	0
5. Human resources (sub-total)	66,185	55,135	0	11,050	0	0
6. Social Protection and Social Services excluding Orphans and Vulnerable Children (sub-total)	0	0	0	0	0	0
7. Enabling Environment (sub-total)	0	0	0	0	0	0
8. Research (sub-total)	0	0	0	0	0	0

National Composite Policy Index

The National Composite Policy Index (NCPI) consists of two parts – Part A and Part B.

Part A is administered to government officials and includes the following:

- Strategic plan
- Political support
- Prevention
- Treatment, care and support
- Monitoring and evaluation.

Part B is administered to representatives from nongovernmental organizations, bilateral agencies, and UN organizations and includes the following:

- Human rights
- Civil society involvement
- Prevention
- Treatment, care and support

For part A, responses were received from the Office of the President, the National AIDS Council (NAC), the Ministry of Finance, the Ministry of Health and Social Development (Public Health Department, Health Services Authority, Youth Health Centres, Social Development Department), Ministry of Education, Ombudsman and the HIV/AIDS/STI Technical Advisory Committee (TAC).

For part B, various stakeholders responded, including Government institutions, private sector, UN agencies and Civil Society Organizations. The following Government institutions responded: The National AIDS Trust Fund (NATF), the Human Rights Commission, the Office of the Attorney General, the Ministry of Foreign Affairs / Indian Ocean Commission Liaison Office. The following UN agencies responded: WHO, UNDP, UNFPA Project. The Barclays Bank (Seychelles) Ltd, Seybrew and the Seychelles Federation of Employers Associations (FEAS) represented the Private Sector's views. On the side of the civil society, responses were received from the Faith and Hope Association (FAHA), the Red Cross Society of Seychelles, Alliance of Solidarity For the Families (ASFF), the HIV/AIDS Support Organization (HASO), and JJ Spirit Foundation Youth Caucus.

Responses from the process, indicate that a national multisectoral strategic plan to combat AIDS was developed, covering the period 2005 to 2009. Sectors are included in the strategic plan and with a specific HIV budget for their activities, including Health, Education, Labour, Military and the Police, Women and Young People.

The plan addresses issues pertaining to the following target populations, settings and cross-cutting issues: women and girls; young men and women; the Most At Risk Populations (MARPS); Gender empowerment and gender equality; Schools; Workplace; Human rights protection. The plan addresses stigma and discrimination as well as the involvement of People Living with HIV.

The target populations were not identified by needs assessments or needs analysis, but by a research conducted in 1997 using biological and behavioural data. Samples from the STI clinic and Ante-Natal Clinic (ANC) were collected and analysed in conjunction with data from interviews conducted on sexual behaviour. These included information on age at first intercourse; sex of partner(s), number of partners, type of sexual intercourse, and use of condom in the last month. The information gathered were used as guidelines to introduce algorithms for the management of STIs and presented in the document entitled 'Management Guidelines for Patients with Sexually Transmitted Diseases 1998'). The guideline provides for special attention to be given to women, young men and women. However, the importance of tailoring interventions to reach men was often not considered. There is a willingness to address this gap and ensure that plans have a special focus on behaviour change for men.

The multi-sectoral strategy includes an operational plan. The operational plan includes: Clear targets and milestones, Formal programme goals, indications of funding source; budget per programmatic area. But the plan did not include a Monitoring and Evaluation framework. This was to be developed after the validation of the plan, unfortunately it did not materialize. The strategy was developed with the "full involvement and participation" of civil society. Civil society organizations were associated at all stages of the development of the Strategy: steering committees, during various workshops and through consultative processes.

Some external development partners, such as UN agencies (WHO, UNDP, UNAIDS, UNFPA) and the Indian Ocean Commission contributed to the development of this plan and aligned and harmonized their HIV-related programmes to the Plan.

The biggest challenge was the development and implementation of the Plans of Action. No annual work plan has been developed to implement the activities of the strategic plan. This led to a lack of methodology and consistency in the implementation of the plan. The lack of a formal and empowered National AIDS Secretariat (NAS) was an additional obstacle to the appropriate follow up of the multi sectoral dimension brought by the plan, and the HIV&AIDS response remained mainly health driven during the period covered by the plan.

Representatives from nongovernmental organizations, bilateral agencies, and UN organizations indicated that laws and regulations are in place to protect people living with HIV against discrimination, including the vulnerable sub-populations. Further, the President chairs the National AIDS Council (NAC) where all stakeholders are represented. People living with HIV/AIDS (PLWHA) have been involved in national and international conferences and trainings and drafting the national policy for HIV prevention and control and the 2005-2009 National Strategic Plan (NSP). PLWHA and youth actively participate in HIV/AIDS prevention activities. However, to date, there are still few leaders openly from most-at-risk populations who are involved in programme implementation. With the introduction of the new Workplace Policy in 2007, further advances have been made in non-discrimination regarding the HIV/AIDS.

Since the last report 2008, there has been some progress made in the implementation of HIV prevention programmes. The programmes are now more specific in their interventions. The number of services for

youth have been increased at the district levels and Faith Based Organizations are more involved in programmes for youth. In addition, secondary prevention has improved. There was more organised coordination of prevention efforts in 2008-2009. The level of coordination has improved in the past two years, especially with stability in AIDS Control Program Management since August 2008. Decentralisation has occurred and more organisations outside the Ministry of Health and Social Development have become active. As the efforts in implementation increase, there is a need to retain the important element of coordination to make our efforts more effective.

B. NATIONAL PROGRAMMES

Indicator 3: Percentage of donated blood units screened for HIV in a quality assured manner

Blood products are living human tissue used in the treatment of patients and, as other biological products, are not without risk. Blood safety is concerned with the overall process of delivering blood products to the patient. A quality assurance system is in place to ensure that the process is safe. This can be ascribed to the efforts in Haemo vigilance to ensure the safety and quality of the blood supply.

Haemo vigilance incorporates the surveillance of procedures carried out at the time of blood collection, the entire blood component processing chain, the transfusion episode, the outcome of the transfusion, as well as an appropriate look-back process. Haemo vigilance thus identifies factors throughout the process that may be related to risk. Haemo vigilance plays a critical role in ensuring that laboratory and clinical blood transfusion practice is optimal.

Seychelles is self-sufficient for blood products and all blood products are procured from voluntary, non-remunerated blood donors. All products are processed, and screened for the presence of transmissible diseases and red cell antibodies before being released for eventual administration to patients. In this chain of events there are numerous activities, which may contribute to transfusion reactions. In the last three decades enormous resources - financially, intellectual, technological and governmental - have been invested in improving the purity, potency and safety of the blood that is collected, tested, packaged, and labelled as suitable for transfusion

Blood transfusion is only done at one location by the Ministry of Health and Social Development and at the Blood Transfusion Centre at the Victoria Hospital – the national reference laboratory, using standard operating procedures and with a quality assurance scheme in place. The following is the reported units of blood screened in a quality assured manner from the Blood Transfusion Centre, Ministry of Health and Social Development, for the two last years' period, starting 1 January 2008 to 31 December 2009.

Table 3: Percentage of donated blood units screened for HIV in a quality assured manner in 2008-2009

	YEAR	
Units of blood	2008	2009
Number of units of blood units transfused	1472	1455
Number of blood units screened for HIV	1472	1455
Number of units screened up to WHO and national standards	1472	1455
% of units screened up to WHO and national standards	100%	100%

Indicator 4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy

Table 4: Percentage of adults and children with advanced HIV infection receiving ART

Sex and age	Number of adults and children with advanced HIV infection who are currently receiving ART at the end of the reporting period	Estimated number of adults and children with advanced HIV infection
2005	<15 Female: 3 <15 Male: 2 15+ Female: 23 15+ Male: 34 Total: 62	<15 Female: 3 <15 Male: 2 15+ Female: 23 15+ Male: 34 Total: 62
2006	<15 Female: 4 <15 Male: 3 15+ Female: 30 15+ Male: 45 Total: 82	<15 Female: 4 <15 Male: 3 15+ Female: 30 15+ Male: 45 Total: 82
2007	<15 Female: 4 <15 Male: 3 15+ Female: 39 15+ Male: 51 Total: 97	<15 Female: 4 <15 Male: 3 15+ Female: 39 15+ Male: 51 Total: 97
2008	<15 Female: 6 <15 Male: 3 15+ Female: 45 15+ Male: 59 Total: 113	<15 Female: 6 <15 Male: 3 15+ Female: 69 15+ Male: 83 Total: 161
2009	<15 Female: 6 <15 Male: 3 15+ Female: 55 15+ Male: 75 Total: 139	<15 Female: 6 <15 Male: 3 15+ Female: 57 15+ Male: 80 Total: 146

Source: Patient Register, CDCU

There are no estimates of the current prevalence of neither HIV nor have estimates of the number in need of ARVs been conducted in Seychelles. Seychelles has a concentrated epidemic and the workbook method of estimates is supposedly a better method for estimation than EPP and SPECTRUM, however the Workbook method does not appear to yield a good measure. In the absence of better estimates, the number of cases detected at Health Centres, meeting WHO Clinical Stage criteria for initiation on ART was used as a proxy for people in need of ARVs. Seychelles already applies the three new WHO recommendations on antiretroviral therapy for adults and adolescents:

- Earlier diagnosis and treatment of HIV in the interest of a prolonged and healthier life;
- Greater use of more patient-friendly regimens;
- Expanded laboratory testing to improve the quality of HIV treatment and care.

Reliable information on the percentage of people with advanced HIV infection receiving antiretroviral combination therapy is obtained from the register of patients kept at the CDCU. This is because there is an extensive network of health centres covering all districts in Seychelles and most people requiring health and medical attention have access to government health service. These services are offered free at the point of service. There are few private medical clinics but over 95% of the population are served by the government run health centres. The data currently available have been compiled from the records of the Communicable Disease Control Unit to which suspected cases from all health facilities are referred for confirmation and case management. These facilities include antenatal clinics, the blood bank, the Occupational Health Unit, hospital services, district health centres and private clinics.

At the end of 2009, there were 139 persons on antiretroviral therapy and being attended to by the Communicable Disease Control Unit (61 females and 78 males). In 2008, there were 113 persons, 51 females and 62 males on antiretroviral therapy. At the end of 2009, more than 95% of people identified as requiring antiretroviral therapy were on treatment. The antiretroviral therapy is free and patients are not required to be on medical schemes or private health insurance. Further, the Ministry of Health and Social Development has issued a series of clinical guidelines for the management of patients infected with HIV and AIDS.

It has been noted that there are more women diagnosed and treated for STIs than men. However, for HIV and AIDS, many more men than women are presenting with symptoms and diagnosed. It has been hypothesized that this is because the epidemic is currently concentrated among MSM.

Indicator 5. Percentage of HIV-positive pregnant women who received antiretroviral to reduce the risk of mother-to-child transmission

Table 5: Percentage of HIV-infected pregnant women who received ARVs to reduce the risk of MTCT

Reporting period	Numerator: Number of HIV-infected pregnant women who received ARVs during the last 12 months to reduce MTCT	Denominator: Estimated number of HIV-infected pregnant women in the last 12 months	Percentage of HIV-infected pregnant women who received ARVs to reduce the risk of MTCT
Jan. 2004-Dec. 2004	7	7	100
Jan. 2005-Dec. 2005	6	6	100
Jan. 2006-Dec. 2006	5	6	83
Jan. 2007-Dec. 2007	3	3	100
Jan. 2008-Dec. 2008	4	4	100
Jan. 2009-Dec. 2009	12	12	100

Sources: CDCU, ANC and ART Patient Records

All the births in Seychelles take place in Maternity Wards of the Ministry of Health and Social Development in all four hospitals. Most of the pregnant women attend ANC. All the pregnant women who attend ANC are tested for HIV. The test is offered twice throughout pregnancy. Those who have never attended ANC are tested before or after giving birth.

Indicator 6. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV

Table 6: Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV: 2004 to 2009

Year	Number of adults with advanced HIV infection who are currently receiving ART and who were started on TB treatment within the reporting year	Detected number of incident TB cases in people living with HIV	Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV
2004	Male: 2 Female: 0 Total: 2	Male: 2 Female: 0 Total: 2	Male: 100% Female: 100% Total: 100%
2005	Male: 1 Female: 1 Total: 2	Male: 1 Female: 1 Total: 2	Male: 100% Female: 100% Total: 100%
2006	Male: 3 Female: 3 Total: 6	Male: 3 Female: 3 Total: 6	Male: 100% Female: 100% Total: 100%
2007	Male: 1 Female: 0 Total: 1	Male: 1 Female: 0 Total: 1	Male: 100% Female: 100% Total: 100%
2008	Male: 0 Female: 0 Total: 0	Male: 0 Female: 0 Total: 0	Male: NA Female: NA Total: NA
2009	Male: 2 Female: 0 Total: 2	Male: 2 Female: 0 Total: 2	Male: 100% Female: 100% Total: 100%

Source:

All patients diagnosed with TB are automatically screened for HIV. All patients who have been identified as HIV-positive are screened for TB if they have a cough or any symptoms related to TB. Suspected cases of TB are referred to the Communicable Disease Control Unit (CDCU) for diagnosis and management. Private Doctors also refer patients to the CDCU. Once the diagnosis is confirmed for TB, the patient is admitted to the Victoria Hospital. Three to four weeks after initiation of treatment, sputum tests are conducted. When all the smears are negative, the patient is discharged from hospital.

DOTS is carried out and arrangements are made with their respective health centres with monthly follow-up at the CDCU. Approximately 95% compliance has been found through the DOTS. If a patient does not come for an appointment that day or the following day, they are usually traced to determine what has happened.

Lately, a number of smear negative cases have been identified that are positive on culture. Sensitivity tests cannot be carried out in Seychelles, specimens must be sent to England (at a high cost). Formal training in sputum smear was not carried out in the lab, due to inadequate capacity in terms of materials and human resources.

Indicator 7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results

Data for this indicator is not available, as no population-based surveys have been conducted recently to include this information. Information available from health centres indicate activities and may the same person performing, thus, we cannot determine the percentage of the population that has received an HIV test in the last 12 months and knows there results.

However, the last population-based survey that was conducted was the KAP study in 2003. It was reported that 1705 persons participated in the study; 538 (31.6%) respondents reported having have had a HIV test; of these 436 (81.0%) reported ever finding out the result.

Indicator 8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know their results

Data for this indicator is not available, as no population-based surveys have been conducted to include this information. Thus, we cannot determine the percentage of most at risk population that has received an HIV test in the last 12 months and knows there results.

Indicator 9. Percentage of most-at-risk populations reached with HIV prevention programmes

Data for this indicator is not available, as no survey has been conducted recently.

Indicator 10. Percentage of orphaned and vulnerable children aged 0–17 whose households received free basic external support in caring for the child

The social security system in Seychelles is organised such that all vulnerable individuals including orphans and vulnerable children are supported. Further, all orphaned and vulnerable children are cared by wither their family or the few orphanages in the country. However, there are no statistics as to the number or percentage of orphaned and vulnerable children whose households received basic external support in caring for the child.

Indicator 11. Percentage of schools that provided life skills-based HIV education in the last academic year

For the last thirty years, the government of Seychelles has laid particular emphasis on the development of two key social institutions; the Ministry of Health and Social Development and the Ministry of Education. This is in line with policies to promote a healthy and educated nation. The Ministry of Education is addressing the issue of HIV and AIDS in the education and training system. The main areas of focus have been implementation of life skills and HIV and AIDS programmes in all primary and secondary schools. This programme also includes the training of teachers, counsellors and peer educators.

Education is free from pre-primary to secondary, and subsidized for tertiary schooling. In general, Seychelles enjoys an estimated 91,5% of adult literacy rate. In 2009, there were 26 primary schools, 3 of which were privately-owned and of the 13 secondary schools, 3 were privately-owned. Post-secondary academic, technical or vocational education is offered in 9 institutions. All children between the ages of 6 and 14 years are enrolled in school.

As part of Life Skills development, education on HIV and AIDS is taught at primary and secondary schools throughout Seychelles as part of the Personal and Social Education component. Except for three private schools, all schools in Seychelles are government run. All teachers have to undergo training at the National Institute of Education before practicing. All schools follow the same syllabus.

C. KNOWLEDGE AND BEHAVIOUR

Indicator 12 : Current school attendance among orphans and among non-orphans aged 10–14

No population-based or representative surveys have been carried out in Seychelles, therefore there is no qualified data. It is the law in Seychelles that all children have to attend school through the age of 15. The law is very strictly enforced and it is likely that there is only a very low percentage of children not attending school.

However, we do have information from the Department of Health and Social Development, which reports that in 2009, there were 135 children on social assistance. Statistics are not collected on whether a child's parents are alive or not. In Seychelles, Orphans are taken in by the President's Village, religious institutions, or family. Statistics are not collected on orphans, per se, but on vulnerable children. However, children are identified as needing social assistance through MEANS testing—this is a battery of indicators that gives a rating of whether support to the child is adequate to sustain them, mostly financial and social indicators regarding household income and (give examples of social indicators).

Indicator 13 : Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

The KAPS was conducted in 2003 whereby 2,000 people were randomly selected from the National Housing and Population Census database (1997). The study focused on individuals aged 15-65 years old and was conducted in 25 health districts. Of all the respondents, 63.4% were males and 36.6% were females, were able to answer questions that would identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV. Unfortunately, no extrapolation has been done for the specific age group 15-24 on this specific indicator.

Indicator 14 : Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

No data is available for this indicator as no survey has been carried out.

Indicator 15 : Percentage of young women and men aged 15–24 who have had sexual intercourse before the age of 15

The latest survey where this information was requested was the National Youth Survey of 1998.

However, a study on knowledge, attitudes and practices (KAP) conducted in January-February 2003 was designed to evaluate the current level of knowledge, attitudes and practices among the Seychellois population from 15-65 years old. A questionnaire pre-tested, anonymous unlinked was administered.

Out of 2,000 persons randomly and proportionally selected based on the population distribution from Mahé, Praslin, La Digue and Silhouette from 26 health districts, 1,706 voluntarily participated.

Males and females were comparable in most of the socio-demographic indicators. The mean age of the respondents was 35.6. Ninety nine percent of the respondents had heard about HIV/AIDS. However, several misconceptions still exist concerning the HIV modes of transmission. Strong association was found between correct attitudes and the level of knowledge of the respondents.

Negative attitudes related to discrimination of people infected or affected with HIV and AIDS are still prevalent. Apart from respondents who were married or living with a regular partner, 81% had experienced sexual intercourse. The median age at first sexual intercourse was 17 years for males and 18 years for females. Males reported more frequently commercial sexual intercourse compared with females ($p=0.0000$). Genital discharge was reported in 2% of the cases and genital ulcers in 1%. Among those who reported having had sex with commercial sexual partners in the past month, 32% (18/56) did not use condoms, mainly due to the fact that they did not like it (45%). Only 2% (39/1692) of respondents did not know a place where condoms could be obtained. The most reported source of information related to male and female condoms was television (54%), radio (18%) and health centres (8%).

The results demonstrate that although the level of information on STI, HIV and AIDS is high, misconceptions still persist. Wrong attitudes and behaviours relating to the disease need to be analysed in a multi-sectoral context, to improve the health education strategies, particularly among youth.

Indicator 16: Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months

Since an important way to reduce the transmission of the AIDS virus is to remain faithful to one partner, the 2003 survey asked questions about the number of partners respondents had in the 12 months preceding the survey. Eleven percent of women respondents reported having more than one sexual partner in the previous year, compared with 23 percent of men. The percentage for both sexes was 16.6%.

Men and women in their 20s are most likely to have multiple partners. Among men, the proportion reporting more than one partner increases with education level; among women, there is no consistent relationship.

Indicator 17 : Percentage of women and men aged 15–49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse

The 2003 survey included a series of questions related to HIV and AIDS and sexually transmitted infections in both the Women's and Men's questionnaires. Since condom use is an important method of preventing the spread of HIV, women were asked about condom use. The data indicate that almost 40 percent of women who had sexual intercourse in the 12 months prior to the survey, said they had ever used a condom. One-third of women said they had used a condom the last time they had sex, though the proportion varies by type of partner. Only 15 percent of women say they use condoms with their husbands or live-in partners, while 47 percent say they used a condom the last time they had sex with a non-cohabiting partner.

Indicator 18 : Percentage of female and male sex workers reporting the use of a condom with their most recent client

No data is available for this indicator as no surveys has been carried out. No study or surveys has taken place amongst Most at Risk Population, including among sex workers.

Indicator 19 : Percentage of men reporting the use of a condom the last time they had anal sex with a male partner

No data is available for this indicator as no study or surveys has taken place amongst Most at Risk Population.

Indicator 20 : Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse

No data is available for this indicator as no study or surveys has taken place amongst Most at Risk Population.

Indicator 21 : Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected

No data is available for this indicator as no study or surveys has taken place amongst Most at Risk Population.

D. IMPACT INDICATORS

Indicator 22 : Percentage of young women and men aged 15 –24 years who are HIV infected

No data is available for this indicator as no survey has been carried out.

Indicator 23 : Percentage of most-at-risk populations who are HIV infected

No data is available for this indicator as no study or surveys has taken place amongst MARPS.

Indicator 24 : Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy

Table 7. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy

Sex and age	Number of adults and children with advanced HIV infection who are currently receiving ART at the end of the reporting period	Estimated number of adults and children with advanced HIV infection
2009	<15 Female: 6 <15 Male: 3 15+ Female: 54 15+ Male: 69 Total: 132	<15 Female: 6 <15 Male: 3 15+ Female: 58 15+ Male: 74 Total: 141

Data from the patient records in 2009 indicate that the percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy was 93.75% males and 93.51% females. Of the 141 patients, 77 males and 64 females, that started treatment in that year, 132 patients were still on treatment 12 months later - 72 males and 60 females,

Indicator no 25 : Percentage of infants born to HIV infected mothers who are infected

Table 8. Percentage of infants born to HIV infected mothers who are infected

YEAR	2008	2009
Number of infants born to HIV infected mothers who are infected	1	0
Total number of infants born to HIV infected mothers	3	7
Percentage of infants born to HIV infected mothers who are infected	33%	0%

7 deliveries from HIV positive mothers in 2009, waiting for confirmation test at 18 months old since early infant diagnosis (PCR) is not available in Seychelles

V. BEST PRACTICES

Health policies and systems

The National Health Policy in Seychelles is based on the principle of Health for all and by all¹⁸. In implementing this policy, the Government's strategy is to ensure that health care services are accessible to all Seychellois and that access is based on need and not ability to pay. That Primary Health Care should be free at the point of delivery is a principle that is engrained in the Constitution. Health services are, therefore, free at the point of use and organized as close as possible to all those who require such services, by spacing health centres such that access time is not more than thirty minutes travel time. In this regard, Government's top priorities are sustained development of Primary Health Care; the development of human resources; quality-assurance and ensuring that the services respond appropriately to changing health needs and situations. Health promotion and protection are emphasized, since most of the health problems are related to changing life styles. Furthermore, with increasing cases of cancer, cardiovascular and chronic degenerative diseases, attention will focus on strengthening the role of secondary and tertiary care for provision of specialized services in support of primary health care.

These stem from the government believe in people centred development and that the health of the people not only contributes to better quality of life but also is essential for the sustained economic and social development of the country as a whole.

Gender Equality

One of the factors that drive the epidemic has been identified as gender inequality. In Seychelles, women and men enjoy full economic, political and civil rights. Seychelles is among the top countries in the Southern Africa Development Community region to have met targets for female representation at all decision-making levels. There is 35 per cent female representation in parliament, 15 per cent at the ministerial level and 45 per cent at chief executive and middle-management levels. However, the low capacity of institutions with responsibility for gender mainstreaming continues to hamper efforts to achieve gender parity. The National Plan of Action for Social Development, 2005-2015, calls for the elaboration of a national gender policy and a national gender action plan to address specific gender issues in line with the Beijing Platform for Action. These include sex-disaggregated data, more reliable national statistics, gender difference, economic areas and sharing parental responsibilities. A main concern is the increased incidence of gender-based violence. Special attention is being paid to the incorporation of gender awareness into policies and programmes through gender-sensitive indicators for monitoring and evaluation.

Health financing and Organisation of Health Services

Since 1977, health has been one of the priority areas in the country's budgetary allocation. It has featured as the most important sector for the years 2008 and 2009, in terms of annual budgetary allocations.

The Ministry of Health and Social Development is the principal provider of health services in Seychelles. It has the overall responsibility for planning, directing and developing the health system for the benefit of the entire population of Seychelles.

The health care system in Seychelles is organized according to three distinct levels, namely primary, secondary and tertiary care. The distribution of health facilities and beds by level of health care also reflects the geographic characteristics of Seychelles, which comprises several islands. Emphasis has been and continues to be on primary health care where most of the disease prevention, health promotion, curative care and rehabilitation take place. To assist in the delivery of primary health care services, the country is divided into sixteen health districts. Each health district has a health centre staffed by a district health team, headed by a Health Coordinator, who is a senior member of the health team. The main function of the health coordinator is to ensure the smooth running of the district health programmes.

VI. MAJOR CHALLENGES AND REMEDIAL ACTIONS

A, major capacity constraints has been identified in Seychelles. There is limited capacity at the systemic, institutional and individual levels as the primary barriers to effective management of health and other commitments. Furthermore, national capacity outside the public sector is not properly harnessed to bridge this gap. The decreasing investment in human capital has forced the country to rely heavily on expatriate labour in several key sectors of the economy. Lack of competent local manpower to match socio-economic development needs poses a serious challenge to the sustainable development of Seychelles.

The country is still heavily dependent on expatriate personnel at the top professional cadres of medical officers and dental officers and consultants. For example for 2007, about 60% of all medical doctors being expatriates, human resources development has been and still is one of the major concerns for the country. This is mainly due to the continuous shortage of nationals trained in the health professions. At that time (2007) there were re 12.5 medical doctors per 10,000 inhabitants, 24 midwives per 10,000 inhabitants and 46.9 nurses per 10,000 inhabitants. Most undergraduate and post-graduate training are done overseas. Special arrangements exist with a number of reputable Universities such as University of Manchester (UK) and Edith Cowan (Australia) where students wishing to pursue studies in certain specific fields do part of their degree courses locally, and recently a local University has been launched. Related to this, one of the main challenges of implementation of HIV&AIDS interventions relates to capacity to implement. At the government level, a particular challenge is the skills building of health workers to ensure they have the clinical skills to manage patients with TB, STIs and opportunistic infections, according to the standard treatment guidelines.

The development and launch of the National Strategic Plan 2005 to 2009 was a significant step towards ensuring that the country had a common strategic approach. This Strategic Plan has been disseminated widely, and specific support has been provided to other government departments and civil society sectors to ensure participation in the implementation of the strategies within the Plan. This provided the impetus for major interventions. However, annual work plans and a monitoring and evaluation framework needed to be developed and implemented in addition. This would have allowed the Government and its partners, especially the NGOS sector, to address key strategies within the Strategic Plan, and closer collaboration in the implementation of these activities. There were also need of carrying out a midterm review of the Strategic Plan to further strengthen the Plan and guide implementation plans and to provide important input for the new plan beyond 2009. These three aspects (Detailed work plans, M&E Framework and plan and organization of mid-term review) are to be particularly considered for the upcoming NSP.

When comparing the Strategic Plan and the activities of Health and Government as it relates to HIV and AIDS, it is clear that the strategies and policies of the country are on track. Unfortunately, the existing frameworks allow to track progress made on the component of Care and Treatment, but few is done to monitor Prevention efforts and Impact Mitigation. The future battle will focus on these two components, especially within MARPS, in other to contain the epidemic. It will be crucial, in the 5 coming years, to move

the fight against HIV&AIDS from the dominant health driven response to a more coordinated multisectoral response.

Even on the component of Care and Treatment, a relatively weak area is a clear and coordinated process for monitoring and evaluation. Most efforts currently are vertical and ad hoc, and do not feed into the national health information system that can provide critical information for planning and monitoring of interventions at district, provincial and national level. The next step is for NAC and the Department of Health to develop a monitoring and evaluation framework that is based on the Strategic Plan, rather than on vertical programmes.

Seychelles is a small country with a limited number of human resources. To evaluate the availability of human resources, the National Strategic Plan 2005 -2009 indicated that it will be necessary to audit the existing human resources at national, regional and district levels. For future planning, such an audit should assist in establishing standards of personnel at district, regional and national levels of management.

VII. SUPPORT REQUIRED FROM COUNTRY'S DEVELOPMENT PARTNERS

Given that the National Strategic Plan 2005-2009 is now over, the effective implementation of relevant HIV & AIDS activities will largely depend on the availability of human, financial and institutional resources to evaluate the previous plan, develop a new one covering the five coming years, and more important, to design and implement Monitoring and Evaluation Framework and Plan.

The sustainability of the response will depend on an efficient monitoring process in the area of policy development, institutional strengthening and service delivery (National AIDS Council, 2005).

Unfortunately Seychelles does not benefit much support from the Development Partners. Seychelles as a middle income island country does not qualify for support from development partners and receives very little support. Most of the indicators used by development partners for support is based on income per capita. Small island population also spend a lot per capita because of the economy of scale. However, even the 'Small Island Developing States' within the south west Indian ocean show disparate per capita expenditure on health. For example, the per-capita expenditure for health per habitant per year ranges from 25 USD in Comoros to 599 in Seychelles (RD Speech). There is however an interesting development to reconsider the case of "Small Island Developing States".

For example, the 'Mauritius Declaration' of January 2005 issued by the United Nations at the occasion of the "International Meeting to Review the implementation of the Programme of Action for Sustainable development of Small Island Developing States", expressed concern about increasing incidence of health issues, and commitment to address them comprehensively, at regional and global level.

Not only It is felt that the issue of vulnerability of island state is not being properly addressed in international forums, but the case of small islands state present a particular problem in terms of health, the MDGs and socio economic development. Though on average Small Islands Developing States are closer to the health Millennium Development Goals and some attained already some of these goals, the vulnerability of these states to HIV and AIDS may present a potential problem. In October 23, 2006, the Seychelles Government and the World Health Organisation co-sponsored the first "Meeting of African Ministers of Health of Small Island Developing States". In his opening address, the Regional Director for WHO AFRO recognised that the "the health situation in the 46 Member-States of WHO African region presents common features but also specificities that are dominant in Island States, for which WHO should dedicate a particular attention".

The initiatives offer for Small Islands Developing States and multi-lateral partners the opportunity to identify and discuss the critical health problems and the way the local infrastructures, especially the health systems are responding to them. It allows the opportunity to exchange experiences and views about the future developments towards the highest possible level of health in your countries. However, few development bilateral partners do support the country and government has instituted a sound framework for the coordination of support activities through the Ministry of Foreign Affairs and International Cooperation.

There are several areas where development partners can play a significant role, especially in strengthening the programmatic capacities – working with both formal government and with the NGOs, which are well structured and have organised between themselves, a high level of coordination by the Liaison Unit of Non Governmental Organisation of Seychelles.

Civil society becoming more organised, has helped with partnership at national and regional levels, such as with WHO, UNDP, UNAIDS, PILS from Mauritius, “RIVE Ocean Indien” and ARPS from La Reunion, AIRIS-Ocean Indian Commission. However, support is at a minimum. Churches and community-based organisations are contributing to HIV and AIDS efforts on a local level.

Support from development partners would go a long way to enhance the ‘Three Ones’ principles applicable to all stakeholders in the country-level HIV/AIDS response:

- **One** agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners.
- **One** National AIDS Coordinating Authority, with a broad based multi-sector mandate.
- **One** agreed country level Monitoring and Evaluation System.

Using these three pillars as the overall focus, a variety of ways can be used to bring together self-coordinating entities, partnerships and funding mechanisms for concerted action.

In Seychelles, the National AIDS Council is the national AIDS coordinating authority. Its main role is to advice government on HIV and AIDS policy; and advocate for the effective involvement of sectors and organisations in implementing programmes and strategies. Unfortunately, without a specific and strong secretariat, NAC operated more as a board than as a daily coordinating entity. Appropriate action is being considered to strengthen this structure, and support is required in providing capacity to assist the National AIDS Council to discharge its function of advocating effective involvement of sectors and organisation.

Support is required in preparation of a new National HIV and AIDS Strategic Plan 2010 -2014 with an operational Plan and a detailed budget. The planning efforts should be renewed annually by the development of annual work plans that build on the real situation in terms of progress in implementing the global Strategic Plan.

The lack of a ‘Monitoring and Evaluation Framework” for the Comprehensive HIV and AIDS Prevention, Care, Management and Treatment programme and in Impact mitigation in Seychelles is a serious obstacle to efficiency. Only this tool can allow an accurate of monitoring the resources invested, the activities implemented, services delivered as well as evaluate outcomes achieved and long-term impact made by the ‘National HIV and AIDS Strategic Plan’.

Another area that requires definite assistance is in the development of capacity and ensuring that programmes are implemented in effective and efficient manner. It is clear from various international consultant ‘missions’ reports and recommendations that the country does not have the requisite capacity to implement certain programmes, yet there is no attempt to support the country to correct these anomalies.

Support would be required to facilitate coordination, monitoring of progress of the national response and alignment to government priorities.

The experience of Seychelles in developing and implementing its health policies, framework and infrastructure in addressing health problems is also the inadequacy in capturing best practices – the experience is that programmes are not well documented, and this makes sharing lessons more difficult. Documenting best practices also plays an important role in being able to communicate efforts.

Amongst challenges that support can benefit the country in addressing not only issues to do with HIV and AIDS but in strengthening the Health Sector when addressing these are: support in strategic and operational planning, including assistance to develop a costed implementation plan and a monitoring and evaluation framework. Particular attention needs to be given to result-based management methodologies. As mentioned earlier, support in estimates and projections of HIV and AIDS is also required.

The joint efforts of Government, Civil Society and development partners towards common goals, as expressed in the Strategic Plan, are crucial to a coordinated response to HIV, AIDS and STIs and support from development partners would go a long way in addressing not only the HIV and AIDS situation, but also by the strengthening of the Health System in general.

Regular meetings of both a high-level policy-oriented working group (NAC) and a technical implementation-focused working group (TAC) need to continue to be functional systems of accountability to ensure that tasks are completed. But without the appropriate human and financial resources gathered in a functioning Secretariat to accomplish designated tasks, the efforts will continue to be scattered.

The most urgent need is to translate recommendations and strategic plans into operations and action for the sake of curbing the epidemic in Seychelles. It is strongly felt that Seychelles has the opportunity to save countless lives and avoid a massive disaster by immediately investing heavily and wisely to prevent the epidemic from having a much greater effect on the most-at-risk populations and exploding in the general population. At present, the epidemic is concentrated in most-at-risk populations about which Seychelles has almost no information and for whom there can be few evidence-based prevention, care, treatment, and support programmes without accurate information about the epidemic and the most-at-risk populations. With increasing bridging to the general population, evidence-based programmes and tailored interventions for a wide range of demographic groups are needed immediately. Surveys among Men who Have Sex with Men, Commercial Sex Workers and IDUs are immediate needs for the country, to determine both the biological and behavioural dimensions in regards to HIV and AIDS within these groups of persons.

At the end of the year 2009, the UN system brought a valuable contribution by putting at the disposal of NAC an HIV&AIDS Technical Advisor who has the status of United Nations Volunteer. It will be important to pursue such efforts by providing competent human resources to help in certain key domains, while contributing to building and strengthening local capacities for program sustainability.

A substantive permanent UNAIDS presence to assist the country in developing and implementing strategies would go a long way in avoiding the aforementioned possible massive disaster posed by the epidemic and in potentially saving countless lives.

VI. MONITORING AND EVALUATION ENVIRONMENT

In Seychelles, there is no integral monitoring and evaluation efforts. There is a need to elaborate and implement a monitoring and evaluation framework for HIV and AIDS. The National Strategic HIV and AIDS plan 2005-2009 spelled out that the HIV/AIDS Strategic Plan must be reviewed periodically at national, sectoral and district levels. Monitoring was to be done quarterly, yearly and after five years to ensure that activities are being implemented according to the plan and that all partners contribute to the accomplishment of policy objectives. All stakeholders, including the MOH, were supposed to submit quarterly reports to NAC on their HIV&AIDS activities. It was expected that a mechanism of constant and consistent reporting by districts and sectors to national structures and vice versa would be developed. Information from the regular review of successes or failures was to be used to serve as a communication tool among stakeholders to provide guidelines on appropriate activities in which to be involved (National AIDS Council, 2005; 64). Unfortunately, few has been done in this area, and the direct consequence is that data is scattered and not consolidated.

Specific measurable targets and indicators need to be developed for each objective. A national behavioural survey that was to be undertaken in 2007 to measure changes in HIV related risk behaviours was not done. There is currently insufficient capacity to establish and maintain a system to produce baseline data and M&E indicators.

No Monitoring and Evaluation framework for the National Strategic HIV and AIDS Plan was developed. However, there are many parallel efforts to monitoring and evaluation which can be brought into together into the national response in an integral component of the HIV and AIDS strategic plan and the generic monitoring, epidemiological and public surveillance role of the Department of Health. These will in line with the “Three Ones” principles. Current specific HIV and AIDS monitoring, surveillance and research activities include:-

- The National Health Information System infrastructure;
- Programme evaluation studies that have been conducted in past. These include studies on evaluation the HIV and AIDS epidemic; and behavioural studies;
- Programme monitoring indicators collected through programme monitoring including reporting of new HIV and AIDS cases, the PMTCT programme monitoring, Patients statistics from the Communicable Disease Control Unit in the Ministry of Health and Social Development, HIV testing at the ANC clinics, etc;

As we have indicated before, there is a need to establish the prevalence of HIV & AIDS. It is recommended that biological surveys need to be conducted to assist in determining prevalence and estimate the needs, as cases detected may not be a good proxy for need and may greatly underestimate needs.

UNAIDS and WHO are required to work with the National AIDS Council to develop a tool for regular monitoring of National Strategic Plan. This support can even go further as to strengthen the Department of Health, Monitoring and Evaluation capacity through support to development of the various components of the National Health Information Systems.

ANNEX1: Consultation/preparation process for the country report on monitoring the progress towards the implementation of the Declaration of Commitment on HIV/AIDS

In endorsing the NCPI, a meeting was organised and hosted by the AIDS Control Programme to achieve agreement and consensus on the documents. The following participated in the meeting and the document was amended and unanimously endorsed.

1. Dr. Anne Gabriel – TAC & UNFPA Project Chairperson
2. Dr. Jastin Bibi – Epidemiologist
3. Dr Shobha Hajarnis – DG Public Health Division
4. Dr Cornelia Atsyor – WHO
5. Miss Rebecca Lousteau Lalanne – UNDP
6. Marianna Toussaint – Red Cross Society of Seychelles
7. Mrs. Jeanine Faure – Focal Person AIRIS - IOC
8. Mr. Justin Freminot – HIV and AIDS Support Organization
9. Ms Michelle Tomkinson – Ministry of Finance
10. Mr. Jude Padayachy – National Bureau of Statistics
11. Mr Joachim Didon – MOHSD – Statistics section
12. Mrs Cesar Carmene – Attorney General Office
13. Mrs Maria Payet – Marie – President’s Office
14. Miss Mary Anne Ernesta – Seychelles Breweries
15. Miss Tania Labiche – Social Development Department
16. Mrs Myra Bijoux - AIDS Control Program
17. Ms Rosie Bistoquet – AIDS Control Program
18. Mr Jacques Sindayigaya - UNAIDS

ANNEX 2: DATA SOURCES AND REFERENCES

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ANNEX 3: CORE TEAM

This document was compiled with the assistance of a multidisciplinary and multi-sectoral core team, which included the following:

Jude Padayach, CEO, National Bureau of Statistics

Dr Justin Bibi, MOH, Medecin Referent

Jeanine Faure, Focal person, AIRIS – IOC Project

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